

Patient History Questionnaire

1. Do you feel you have a hearing loss?YES NO
 If YES, please answer the questions below:
 a) How long have you had the problem? _____
 b) Severity of loss _____
 c) Do you hear better in one ear than the other? Please circle: RIGHT or LEFT

2. Do you hear ringing or buzzing in your ears or other head noises?.....YES NO
 If YES, please answer the questions below:
 Please circle which ear(s): Right Left Both
 How long has the noise been present? _____
 High or low pitched? _____
 Single noise or multiple sounds? _____
 Pulsation or Rhythmic quality present? _____
 Constant or Intermittent? _____
 If intermittent, how often and how long does it last? _____

3. Have you had any ear infections, drainage or ear surgeries?.....YES NO
 If YES, please answer the questions below:
 Please indicate as a: Child Adult Both
 Last infection date: _____

4. Have you had any significant noise exposure either work or hobby related?...YES NO
 If YES, please answer the question below:
 Describe how long and what types: _____

5. Do you have any family members that had hearing loss before age fifty? YES NO
 If YES, please answer the question below:
 Relationship: _____

6. Have you experienced dizziness within the last six months?.....YES NO
 If YES, please answer the question below:
 Circle if you experience: Lightheadedness Spinning Sensation

7. Have you ever worn or tried hearing instruments?YES NO
 If YES, please answer the questions below:
 How long ago? _____ Where did you purchase them? _____

8. When was the last time you had your hearing tested and where?

9. Check all that apply to your hearing difficulties:
 - Difficulty hearing some people's voices on the telephone
 - One-to-one conversations
 - In the presence of background noise
 - Groups of people or multiple talkers
 - Women and children voices
 - TV volume is loud to others

10. List medications that you are taking and **for what reason?**

